
HOUSE BILL 2949

State of Washington 59th Legislature 2006 Regular Session

By Representatives Fromhold, Hinkle, Moeller, Green, Morrell, Schual-Berke, Appleton and Linville

Read first time 01/17/2006. Referred to Committee on Appropriations.

1 AN ACT Relating to revising the nursing facility payment system;
2 amending RCW 74.46.431, 74.46.433, 74.46.496, 74.46.501, 74.46.506,
3 74.46.511, 74.46.515, and 74.46.521; creating a new section; and
4 declaring an emergency.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 **Sec. 1.** RCW 74.46.431 and 2005 c 518 s 944 are each amended to
7 read as follows:

8 (1) Effective July 1, 1999, nursing facility medicaid payment rate
9 allocations shall be facility-specific and shall have seven components:
10 Direct care, therapy care, support services, operations, property,
11 financing allowance, and variable return. The department shall
12 establish and adjust each of these components, as provided in this
13 section and elsewhere in this chapter, for each medicaid nursing
14 facility in this state.

15 (2) All component rate allocations for essential community
16 providers as defined in this chapter shall be based upon a minimum
17 facility occupancy of eighty-five percent of licensed beds, regardless
18 of how many beds are set up or in use. For all facilities other than
19 essential community providers, effective July 1, 2001, component rate

1 allocations in direct care, therapy care, support services, variable
2 return, operations, property, and financing allowance shall continue to
3 be based upon a minimum facility occupancy of eighty-five percent of
4 licensed beds. For all facilities other than essential community
5 providers, effective July 1, 2002, the component rate allocations in
6 operations, property, and financing allowance shall be based upon a
7 minimum facility occupancy of ninety percent of licensed beds,
8 regardless of how many beds are set up or in use. Effective January 1,
9 2006, through June 30, 2007, a minimum occupancy factor shall not be
10 applied to the direct care rate component for any facility.

11 (3) Information and data sources used in determining medicaid
12 payment rate allocations, including formulas, procedures, cost report
13 periods, resident assessment instrument formats, resident assessment
14 methodologies, and resident classification and case mix weighting
15 methodologies, may be substituted or altered from time to time as
16 determined by the department.

17 (4)(a) Direct care component rate allocations shall be established
18 using adjusted cost report data covering at least six months. Adjusted
19 cost report data from 1996 will be used for October 1, 1998, through
20 June 30, 2001, direct care component rate allocations; adjusted cost
21 report data from 1999 will be used for July 1, 2001, through June 30,
22 2005, direct care component rate allocations. Adjusted cost report
23 data from 1999 will continue to be used for July 1, 2005, ~~((and later))~~
24 through December 31, 2005, direct care component rate allocations.
25 Adjusted cost report data from 2003 will be used for January 1, 2006,
26 through June 30, 2007, direct care component rate allocations.

27 (b) Direct care component rate allocations based on 1996 cost
28 report data shall be adjusted annually for economic trends and
29 conditions by a factor or factors defined in the biennial
30 appropriations act. A different economic trends and conditions
31 adjustment factor or factors may be defined in the biennial
32 appropriations act for facilities whose direct care component rate is
33 set equal to their adjusted June 30, 1998, rate, as provided in RCW
34 74.46.506(5)(i).

35 (c) Direct care component rate allocations based on 1999 cost
36 report data shall be adjusted annually for economic trends and
37 conditions by a factor or factors defined in the biennial
38 appropriations act. A different economic trends and conditions

1 adjustment factor or factors may be defined in the biennial
2 appropriations act for facilities whose direct care component rate is
3 set equal to their adjusted June 30, 1998, rate, as provided in RCW
4 74.46.506(5)(i).

5 (d) Beginning on January 1, 2006, direct care component rate
6 allocations established upon 2003 cost report data shall be adjusted
7 for economic trends and conditions by a factor or factors defined in
8 the biennial appropriations act.

9 (5)(a) Therapy care component rate allocations shall be established
10 using adjusted cost report data covering at least six months. Adjusted
11 cost report data from 1996 will be used for October 1, 1998, through
12 June 30, 2001, therapy care component rate allocations; adjusted cost
13 report data from 1999 will be used for July 1, 2001, through June 30,
14 2005, therapy care component rate allocations. Adjusted cost report
15 data from 1999 will continue to be used for July 1, 2005, and later
16 therapy care component rate allocations.

17 (b) Therapy care component rate allocations shall be adjusted
18 annually for economic trends and conditions by a factor or factors
19 defined in the biennial appropriations act until December 31, 2005.

20 (c) Effective January 1, 2006, through June 30, 2007, the therapy
21 care component rate allocation shall be adjusted for economic trends
22 and conditions by a factor or factors defined in the biennial
23 appropriations act.

24 (6)(a) Support services component rate allocations shall be
25 established using adjusted cost report data covering at least six
26 months. Adjusted cost report data from 1996 shall be used for October
27 1, 1998, through June 30, 2001, support services component rate
28 allocations; adjusted cost report data from 1999 shall be used for July
29 1, 2001, through June 30, 2005, support services component rate
30 allocations. Adjusted cost report data from 1999 will continue to be
31 used for July 1, 2005, and later support services component rate
32 allocations.

33 (b) Support services component rate allocations shall be adjusted
34 annually for economic trends and conditions by a factor or factors
35 defined in the biennial appropriations act until December 31, 2005.

36 (c) Effective January 1, 2006, through June 30, 2007, the support
37 services component rate allocation shall be adjusted for economic

1 trends and conditions by a factor or factors defined in the biennial
2 appropriations act.

3 (7)(a) Operations component rate allocations shall be established
4 using adjusted cost report data covering at least six months. Adjusted
5 cost report data from 1996 shall be used for October 1, 1998, through
6 June 30, 2001, operations component rate allocations; adjusted cost
7 report data from 1999 shall be used for July 1, 2001, through June 30,
8 2005, operations component rate allocations. Adjusted cost report data
9 from 1999 will continue to be used for July 1, 2005, and later
10 operations component rate allocations.

11 (b) Operations component rate allocations shall be adjusted
12 annually for economic trends and conditions by a factor or factors
13 defined in the biennial appropriations act until December 31, 2005.

14 (c) Effective January 1, 2006, through June 30, 2007, the
15 operations component rate allocation shall be adjusted for economic
16 trends and conditions by a factor or factors defined in the biennial
17 appropriations act.

18 (8) For July 1, 1998, through September 30, 1998, a facility's
19 property and return on investment component rates shall be the
20 facility's June 30, 1998, property and return on investment component
21 rates, without increase. For October 1, 1998, through June 30, 1999,
22 a facility's property and return on investment component rates shall be
23 rebased utilizing 1997 adjusted cost report data covering at least six
24 months of data.

25 (9) Total payment rates under the nursing facility medicaid payment
26 system shall not exceed facility rates charged to the general public
27 for comparable services.

28 (10) Medicaid contractors shall pay to all facility staff a minimum
29 wage of the greater of the state minimum wage or the federal minimum
30 wage.

31 (11) The department shall establish in rule procedures, principles,
32 and conditions for determining component rate allocations for
33 facilities in circumstances not directly addressed by this chapter,
34 including but not limited to: The need to prorate inflation for
35 partial-period cost report data, newly constructed facilities, existing
36 facilities entering the medicaid program for the first time or after a
37 period of absence from the program, existing facilities with expanded
38 new bed capacity, existing medicaid facilities following a change of

1 ownership of the nursing facility business, facilities banking beds or
2 converting beds back into service, facilities temporarily reducing the
3 number of set-up beds during a remodel, facilities having less than six
4 months of either resident assessment, cost report data, or both, under
5 the current contractor prior to rate setting, and other circumstances.

6 (12) The department shall establish in rule procedures, principles,
7 and conditions, including necessary threshold costs, for adjusting
8 rates to reflect capital improvements or new requirements imposed by
9 the department or the federal government. Any such rate adjustments
10 are subject to the provisions of RCW 74.46.421.

11 (13) Effective July 1, 2001, medicaid rates shall continue to be
12 revised downward in all components, in accordance with department
13 rules, for facilities converting banked beds to active service under
14 chapter 70.38 RCW, by using the facility's increased licensed bed
15 capacity to recalculate minimum occupancy for rate setting. However,
16 for facilities other than essential community providers which bank beds
17 under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be
18 revised upward, in accordance with department rules, in direct care,
19 therapy care, support services, and variable return components only, by
20 using the facility's decreased licensed bed capacity to recalculate
21 minimum occupancy for rate setting, but no upward revision shall be
22 made to operations, property, or financing allowance component rates.
23 The direct care rate component allocation shall be adjusted, without
24 using the minimum occupancy threshold, for facilities that convert
25 banked beds to active service, under chapter 70.38 RCW, beginning on
26 January 1, 2006, through June 30, 2007.

27 (14) Facilities obtaining a certificate of need or a certificate of
28 need exemption under chapter 70.38 RCW after June 30, 2001, must have
29 a certificate of capital authorization in order for (a) the
30 depreciation resulting from the capitalized addition to be included in
31 calculation of the facility's property component rate allocation; and
32 (b) the net invested funds associated with the capitalized addition to
33 be included in calculation of the facility's financing allowance rate
34 allocation.

35 **Sec. 2.** RCW 74.46.433 and 2001 1st sp.s. c 8 s 6 are each amended
36 to read as follows:

1 (1) The department shall establish for each medicaid nursing
2 facility a variable return component rate allocation. In determining
3 the variable return allowance:

4 (a) The variable return array and percentage shall be assigned
5 whenever rebasing of noncapital rate allocations is scheduled under RCW
6 (~~(46.46.431-[74.46.431])~~) 74.46.431 (4), (5), (6), and (7).

7 (b) To calculate the array of facilities for the July 1, 2001, rate
8 setting, the department, without using peer groups, shall first rank
9 all facilities in numerical order from highest to lowest according to
10 each facility's examined and documented, but unlidded, combined direct
11 care, therapy care, support services, and operations per resident day
12 cost from the 1999 cost report period. However, before being combined
13 with other per resident day costs and ranked, a facility's direct care
14 cost per resident day shall be adjusted to reflect its facility average
15 case mix index, to be averaged from the four calendar quarters of 1999,
16 weighted by the facility's resident days from each quarter, under RCW
17 74.46.501(7)(b)(ii). The array shall then be divided into four
18 quartiles, each containing, as nearly as possible, an equal number of
19 facilities, and four percent shall be assigned to facilities in the
20 lowest quartile, three percent to facilities in the next lowest
21 quartile, two percent to facilities in the next highest quartile, and
22 one percent to facilities in the highest quartile.

23 (c) To calculate the array of facilities for January 1, 2006, and
24 July 1, 2006, rate setting, the department, without using peer groups,
25 shall first rank all facilities in numerical order from highest to
26 lowest according to each facility's examined and documented, but
27 unlidded, combined direct care, therapy care, support services, and
28 operations per resident day cost from the calendar year cost report
29 period specified in RCW 74.46.431. However, before being combined with
30 other per resident day costs and ranked, a facility's direct care cost
31 per resident day shall be adjusted to reflect its facility average case
32 mix index, to be averaged from the four calendar quarters of the cost
33 report period used to rebase the January 1, 2006, component rate
34 allocations, weighted by the facility's resident days from each quarter
35 under RCW 74.46.501(7)(b)(iii). The array shall then be divided into
36 four quartiles, each containing, as nearly as possible, an equal number
37 of facilities, and four percent shall be assigned to facilities in the
38 lowest quartile, three percent to facilities in the next lowest

1 quartile, two percent to facilities in the next highest quartile, and
2 one percent to facilities in the highest quartile. The department
3 shall(~~(, subject to (d) of this subsection,~~) compute the variable
4 return allowance by multiplying a facility's assigned percentage by the
5 sum of the facility's direct care, therapy care, support services, and
6 operations component rates determined in accordance with this chapter
7 and rules adopted by the department.

8 ~~((d) Effective July 1, 2001, if a facility's examined and~~
9 ~~documented direct care cost per resident day for the preceding report~~
10 ~~year is lower than its average direct care component rate weighted by~~
11 ~~medicaid resident days for the same year, the facility's direct care~~
12 ~~cost shall be substituted for its July 1, 2001, direct care component~~
13 ~~rate, and its variable return component rate shall be determined or~~
14 ~~adjusted each July 1st by multiplying the facility's assigned~~
15 ~~percentage by the sum of the facility's July 1, 2001, therapy care,~~
16 ~~support services, and operations component rates, and its direct care~~
17 ~~cost per resident day for the preceding year.))~~

18 (2) The variable return rate allocation calculated in accordance
19 with this section shall be adjusted to the extent necessary to comply
20 with RCW 74.46.421.

21 **Sec. 3.** RCW 74.46.496 and 1998 c 322 s 23 are each amended to read
22 as follows:

23 (1) Each case mix classification group shall be assigned a case mix
24 weight. The case mix weight for each resident of a nursing facility
25 for each calendar quarter shall be based on data from resident
26 assessment instruments completed for the resident and weighted by the
27 number of days the resident was in each case mix classification group.
28 Days shall be counted as provided in this section.

29 (2) The case mix weights shall be based on the average minutes per
30 registered nurse, licensed practical nurse, and certified nurse aide,
31 for each case mix group, and using the health care financing
32 administration of the United States department of health and human
33 services 1995 nursing facility staff time measurement study stemming
34 from its multistate nursing home case mix and quality demonstration
35 project. Those minutes shall be weighted by statewide ratios of
36 registered nurse to certified nurse aide, and licensed practical nurse

1 to certified nurse aide, wages, including salaries and benefits, which
2 shall be based on 1995 cost report data for this state.

3 (3) The case mix weights shall be determined as follows:

4 (a) Set the certified nurse aide wage weight at 1.000 and calculate
5 wage weights for registered nurse and licensed practical nurse average
6 wages by dividing the certified nurse aide average wage into the
7 registered nurse average wage and licensed practical nurse average
8 wage;

9 (b) Calculate the total weighted minutes for each case mix group in
10 the resource utilization group III classification system by multiplying
11 the wage weight for each worker classification by the average number of
12 minutes that classification of worker spends caring for a resident in
13 that resource utilization group III classification group, and summing
14 the products;

15 (c) Assign a case mix weight of 1.000 to the resource utilization
16 group III classification group with the lowest total weighted minutes
17 and calculate case mix weights by dividing the lowest group's total
18 weighted minutes into each group's total weighted minutes and rounding
19 weight calculations to the third decimal place.

20 (4) The case mix weights in this state may be revised if the health
21 care financing administration updates its nursing facility staff time
22 measurement studies. The case mix weights shall be revised, but only
23 when direct care component rates are cost-rebased as provided in
24 subsection (5) of this section, to be effective on the July 1st
25 effective date of each cost-rebased direct care component rate.
26 However, the department may revise case mix weights more frequently if,
27 and only if, significant variances in wage ratios occur among direct
28 care staff in the different caregiver classifications identified in
29 this section.

30 (5) Case mix weights shall be revised when direct care component
31 rates are cost-rebased (~~((every three years))~~) as provided in RCW
32 74.46.431(4)((~~a~~)).

33 **Sec. 4.** RCW 74.46.501 and 2001 1st sp.s. c 8 s 9 are each amended
34 to read as follows:

35 (1) From individual case mix weights for the applicable quarter,
36 the department shall determine two average case mix indexes for each

1 medicaid nursing facility, one for all residents in the facility, known
2 as the facility average case mix index, and one for medicaid residents,
3 known as the medicaid average case mix index.

4 (2)(a) In calculating a facility's two average case mix indexes for
5 each quarter, the department shall include all residents or medicaid
6 residents, as applicable, who were physically in the facility during
7 the quarter in question (January 1st through March 31st, April 1st
8 through June 30th, July 1st through September 30th, or October 1st
9 through December 31st).

10 (b) The facility average case mix index shall exclude all default
11 cases as defined in this chapter. However, the medicaid average case
12 mix index shall include all default cases.

13 (3) Both the facility average and the medicaid average case mix
14 indexes shall be determined by multiplying the case mix weight of each
15 resident, or each medicaid resident, as applicable, by the number of
16 days, as defined in this section and as applicable, the resident was at
17 each particular case mix classification or group, and then averaging.

18 (4)(a) In determining the number of days a resident is classified
19 into a particular case mix group, the department shall determine a
20 start date for calculating case mix grouping periods as follows:

21 (i) If a resident's initial assessment for a first stay or a return
22 stay in the nursing facility is timely completed and transmitted to the
23 department by the cutoff date under state and federal requirements and
24 as described in subsection (5) of this section, the start date shall be
25 the later of either the first day of the quarter or the resident's
26 facility admission or readmission date;

27 (ii) If a resident's significant change, quarterly, or annual
28 assessment is timely completed and transmitted to the department by the
29 cutoff date under state and federal requirements and as described in
30 subsection (5) of this section, the start date shall be the date the
31 assessment is completed;

32 (iii) If a resident's significant change, quarterly, or annual
33 assessment is not timely completed and transmitted to the department by
34 the cutoff date under state and federal requirements and as described
35 in subsection (5) of this section, the start date shall be the due date
36 for the assessment.

37 (b) If state or federal rules require more frequent assessment, the

1 same principles for determining the start date of a resident's
2 classification in a particular case mix group set forth in subsection
3 (4)(a) of this section shall apply.

4 (c) In calculating the number of days a resident is classified into
5 a particular case mix group, the department shall determine an end date
6 for calculating case mix grouping periods as follows:

7 (i) If a resident is discharged before the end of the applicable
8 quarter, the end date shall be the day before discharge;

9 (ii) If a resident is not discharged before the end of the
10 applicable quarter, the end date shall be the last day of the quarter;

11 (iii) If a new assessment is due for a resident or a new assessment
12 is completed and transmitted to the department, the end date of the
13 previous assessment shall be the earlier of either the day before the
14 assessment is due or the day before the assessment is completed by the
15 nursing facility.

16 (5) The cutoff date for the department to use resident assessment
17 data, for the purposes of calculating both the facility average and the
18 medicaid average case mix indexes, and for establishing and updating a
19 facility's direct care component rate, shall be one month and one day
20 after the end of the quarter for which the resident assessment data
21 applies.

22 (6) A threshold of ninety percent, as described and calculated in
23 this subsection, shall be used to determine the case mix index each
24 quarter. The threshold shall also be used to determine which
25 facilities' costs per case mix unit are included in determining the
26 ceiling, floor, and price. For direct care component rate allocations
27 established on and after January 1, 2006, the threshold of ninety
28 percent shall be used to determine the case mix index each quarter and
29 to determine which facilities' costs per case mix unit are included in
30 determining the ceiling and price. If the facility does not meet the
31 ninety percent threshold, the department may use an alternate case mix
32 index to determine the facility average and medicaid average case mix
33 indexes for the quarter. The threshold is a count of unique minimum
34 data set assessments, and it shall include resident assessment
35 instrument tracking forms for residents discharged prior to completing
36 an initial assessment. The threshold is calculated by dividing a
37 facility's count of residents being assessed by the average census for
38 the facility. A daily census shall be reported by each nursing

1 facility as it transmits assessment data to the department. The
2 department shall compute a quarterly average census based on the daily
3 census. If no census has been reported by a facility during a
4 specified quarter, then the department shall use the facility's
5 licensed beds as the denominator in computing the threshold.

6 (7)(a) Although the facility average and the medicaid average case
7 mix indexes shall both be calculated quarterly, the facility average
8 case mix index will be used (~~only every three years~~) throughout the
9 applicable cost-rebasing period in combination with cost report data as
10 specified by RCW 74.46.431 and 74.46.506, to establish a facility's
11 allowable cost per case mix unit. A facility's medicaid average case
12 mix index shall be used to update a nursing facility's direct care
13 component rate quarterly.

14 (b) The facility average case mix index used to establish each
15 nursing facility's direct care component rate shall be based on an
16 average of calendar quarters of the facility's average case mix
17 indexes.

18 (i) For October 1, 1998, direct care component rates, the
19 department shall use an average of facility average case mix indexes
20 from the four calendar quarters of 1997.

21 (ii) For July 1, 2001, direct care component rates, the department
22 shall use an average of facility average case mix indexes from the four
23 calendar quarters of 1999.

24 (iii) Beginning on January 1, 2006, through June 30, 2007, when
25 establishing the direct care component rates, the department shall use
26 an average of facility case mix indexes from the four calendar quarters
27 occurring during the cost report period used to rebase the direct care
28 component rate allocations as specified in RCW 74.46.431.

29 (c) The medicaid average case mix index used to update or
30 recalibrate a nursing facility's direct care component rate quarterly
31 shall be from the calendar quarter commencing six months prior to the
32 effective date of the quarterly rate. For example, October 1, 1998,
33 through December 31, 1998, direct care component rates shall utilize
34 case mix averages from the April 1, 1998, through June 30, 1998,
35 calendar quarter, and so forth.

36 **Sec. 5.** RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each amended
37 to read as follows:

1 (1) The direct care component rate allocation corresponds to the
2 provision of nursing care for one resident of a nursing facility for
3 one day, including direct care supplies. Therapy services and
4 supplies, which correspond to the therapy care component rate, shall be
5 excluded. The direct care component rate includes elements of case mix
6 determined consistent with the principles of this section and other
7 applicable provisions of this chapter.

8 (2) Beginning October 1, 1998, the department shall determine and
9 update quarterly for each nursing facility serving medicaid residents
10 a facility-specific per-resident day direct care component rate
11 allocation, to be effective on the first day of each calendar quarter.
12 In determining direct care component rates the department shall
13 utilize, as specified in this section, minimum data set resident
14 assessment data for each resident of the facility, as transmitted to,
15 and if necessary corrected by, the department in the resident
16 assessment instrument format approved by federal authorities for use in
17 this state.

18 (3) The department may question the accuracy of assessment data for
19 any resident and utilize corrected or substitute information, however
20 derived, in determining direct care component rates. The department is
21 authorized to impose civil fines and to take adverse rate actions
22 against a contractor, as specified by the department in rule, in order
23 to obtain compliance with resident assessment and data transmission
24 requirements and to ensure accuracy.

25 (4) Cost report data used in setting direct care component rate
26 allocations shall be 1996 and 1999((~~7~~)) for rate periods ending
27 December 31, 2005, and shall be the 2003 cost report data for direct
28 care component rate allocations set beginning January 1, 2006, through
29 June 30, 2007, as specified in RCW 74.46.431(4)(a).

30 (5) Beginning October 1, 1998, the department shall rebase each
31 nursing facility's direct care component rate allocation as described
32 in RCW 74.46.431, adjust its direct care component rate allocation for
33 economic trends and conditions as described in RCW 74.46.431, and
34 update its medicaid average case mix index, consistent with the
35 following:

36 (a) Reduce total direct care costs reported by each nursing
37 facility for the applicable cost report period specified in RCW

1 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
2 reported resident therapy costs and adjustments, in order to derive the
3 facility's total allowable direct care cost;

4 (b) Divide each facility's total allowable direct care cost by its
5 adjusted resident days for the same report period, increased if
6 necessary to a minimum occupancy of eighty-five percent; that is, the
7 greater of actual or imputed occupancy at eighty-five percent of
8 licensed beds, to derive the facility's allowable direct care cost per
9 resident day. However, effective January 1, 2006, through June 30,
10 2007, each facility's allowable direct care costs shall be divided by
11 its adjusted resident days without application of a minimum occupancy
12 threshold;

13 (c) Adjust the facility's per resident day direct care cost by the
14 applicable factor specified in RCW 74.46.431(4) (b) (~~and~~), (c), and
15 (d) to derive its adjusted allowable direct care cost per resident day;

16 (d) Divide each facility's adjusted allowable direct care cost per
17 resident day by the facility average case mix index for the applicable
18 quarters specified by RCW 74.46.501(7)(b) to derive the facility's
19 allowable direct care cost per case mix unit;

20 (e) Effective for July 1, 2001, rate setting, divide nursing
21 facilities into at least two and, if applicable, three peer groups:
22 Those located in nonurban counties; those located in high labor-cost
23 counties, if any; and those located in other urban counties;

24 (f) Array separately the allowable direct care cost per case mix
25 unit for all facilities in nonurban counties; for all facilities in
26 high labor-cost counties, if applicable; and for all facilities in
27 other urban counties, and determine the median allowable direct care
28 cost per case mix unit for each peer group;

29 (g) Except as provided in (i) of this subsection, from October 1,
30 1998, through June 30, 2000, determine each facility's quarterly direct
31 care component rate as follows:

32 (i) Any facility whose allowable cost per case mix unit is less
33 than eighty-five percent of the facility's peer group median
34 established under (f) of this subsection shall be assigned a cost per
35 case mix unit equal to eighty-five percent of the facility's peer group
36 median, and shall have a direct care component rate allocation equal to
37 the facility's assigned cost per case mix unit multiplied by that

1 facility's medicaid average case mix index from the applicable quarter
2 specified in RCW 74.46.501(7)(c);

3 (ii) Any facility whose allowable cost per case mix unit is greater
4 than one hundred fifteen percent of the peer group median established
5 under (f) of this subsection shall be assigned a cost per case mix unit
6 equal to one hundred fifteen percent of the peer group median, and
7 shall have a direct care component rate allocation equal to the
8 facility's assigned cost per case mix unit multiplied by that
9 facility's medicaid average case mix index from the applicable quarter
10 specified in RCW 74.46.501(7)(c);

11 (iii) Any facility whose allowable cost per case mix unit is
12 between eighty-five and one hundred fifteen percent of the peer group
13 median established under (f) of this subsection shall have a direct
14 care component rate allocation equal to the facility's allowable cost
15 per case mix unit multiplied by that facility's medicaid average case
16 mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

17 (h) Except as provided in (i) of this subsection, from July 1,
18 2000, (~~(forward, and for all future rate setting)~~) through December 31,
19 2005, determine each facility's quarterly direct care component rate as
20 follows:

21 (i) Any facility whose allowable cost per case mix unit is less
22 than ninety percent of the facility's peer group median established
23 under (f) of this subsection shall be assigned a cost per case mix unit
24 equal to ninety percent of the facility's peer group median, and shall
25 have a direct care component rate allocation equal to the facility's
26 assigned cost per case mix unit multiplied by that facility's medicaid
27 average case mix index from the applicable quarter specified in RCW
28 74.46.501(7)(c);

29 (ii) Any facility whose allowable cost per case mix unit is greater
30 than one hundred ten percent of the peer group median established under
31 (f) of this subsection shall be assigned a cost per case mix unit equal
32 to one hundred ten percent of the peer group median, and shall have a
33 direct care component rate allocation equal to the facility's assigned
34 cost per case mix unit multiplied by that facility's medicaid average
35 case mix index from the applicable quarter specified in RCW
36 74.46.501(7)(c);

37 (iii) Any facility whose allowable cost per case mix unit is
38 between ninety and one hundred ten percent of the peer group median

1 established under (f) of this subsection shall have a direct care
2 component rate allocation equal to the facility's allowable cost per
3 case mix unit multiplied by that facility's medicaid average case mix
4 index from the applicable quarter specified in RCW 74.46.501(7)(c);

5 (i)(i) Between October 1, 1998, and June 30, 2000, the department
6 shall compare each facility's direct care component rate allocation
7 calculated under (g) of this subsection with the facility's nursing
8 services component rate in effect on September 30, 1998, less therapy
9 costs, plus any exceptional care offsets as reported on the cost
10 report, adjusted for economic trends and conditions as provided in RCW
11 74.46.431. A facility shall receive the higher of the two rates.

12 (ii) Between July 1, 2000, and June 30, 2002, the department shall
13 compare each facility's direct care component rate allocation
14 calculated under (h) of this subsection with the facility's direct care
15 component rate in effect on June 30, 2000. A facility shall receive
16 the higher of the two rates. Between July 1, 2001, and June 30, 2002,
17 if during any quarter a facility whose rate paid under (h) of this
18 subsection is greater than either the direct care rate in effect on
19 June 30, 2000, or than that facility's allowable direct care cost per
20 case mix unit calculated in (d) of this subsection multiplied by that
21 facility's medicaid average case mix index from the applicable quarter
22 specified in RCW 74.46.501(7)(c), the facility shall be paid in that
23 and each subsequent quarter pursuant to (h) of this subsection and
24 shall not be entitled to the greater of the two rates.

25 (iii) Effective July 1, 2002, through December 31, 2005, all direct
26 care component rate allocations shall be as determined under (h) of
27 this subsection;

28 (j) Effective January 1, 2006, through June 30, 2007, determine
29 each facility's quarterly direct care component rate as follows:

30 (i) Any facility whose allowable cost per case mix unit is greater
31 than one hundred fifteen percent of the peer group median established
32 under (f) of this subsection shall be assigned a cost per case mix unit
33 equal to one hundred fifteen percent of the peer group median, and
34 shall have a direct care component rate allocation equal to the
35 facility's assigned cost per case mix unit multiplied by that
36 facility's medicaid average case mix index from the applicable quarter
37 specified in RCW 74.46.501(7)(c);

1 (ii) Any facility whose allowable cost per case mix unit is less
2 than one hundred fifteen percent of the peer group median established
3 under (f) of this subsection shall have a direct care component rate
4 allocation equal to the facility's allowable cost per case mix unit
5 multiplied by that facility's medicaid average case mix index from the
6 applicable quarter specified in RCW 74.46.501(7)(c).

7 (6) The direct care component rate allocations calculated in
8 accordance with this section shall be adjusted to the extent necessary
9 to comply with RCW 74.46.421.

10 (7) Payments resulting from increases in direct care component
11 rates, granted under authority of RCW 74.46.508(1) for a facility's
12 exceptional care residents, shall be offset against the facility's
13 examined, allowable direct care costs, for each report year or partial
14 period such increases are paid. Such reductions in allowable direct
15 care costs shall be for rate setting, settlement, and other purposes
16 deemed appropriate by the department.

17 **Sec. 6.** RCW 74.46.511 and 2001 1st sp.s. c 8 s 11 are each amended
18 to read as follows:

19 (1) The therapy care component rate allocation corresponds to the
20 provision of medicaid one-on-one therapy provided by a qualified
21 therapist as defined in this chapter, including therapy supplies and
22 therapy consultation, for one day for one medicaid resident of a
23 nursing facility. The therapy care component rate allocation for
24 October 1, 1998, through June 30, 2001, shall be based on adjusted
25 therapy costs and days from calendar year 1996. The therapy component
26 rate allocation for July 1, 2001, through June 30, (~~2004~~) 2007, shall
27 be based on adjusted therapy costs and days from calendar year 1999.
28 The therapy care component rate shall be adjusted for economic trends
29 and conditions as specified in RCW 74.46.431(5) (b)(~~7~~) and (c) and
30 shall be determined in accordance with this section.

31 (2) In rebasing, as provided in RCW 74.46.431(5)(a), the department
32 shall take from the cost reports of facilities the following reported
33 information:

34 (a) Direct one-on-one therapy charges for all residents by payer
35 including charges for supplies;

36 (b) The total units or modules of therapy care for all residents by

1 type of therapy provided, for example, speech or physical. A unit or
2 module of therapy care is considered to be fifteen minutes of one-on-
3 one therapy provided by a qualified therapist or support personnel; and

4 (c) Therapy consulting expenses for all residents.

5 (3) The department shall determine for all residents the total cost
6 per unit of therapy for each type of therapy by dividing the total
7 adjusted one-on-one therapy expense for each type by the total units
8 provided for that therapy type.

9 (4) The department shall divide medicaid nursing facilities in this
10 state into two peer groups:

11 (a) Those facilities located within urban counties; and

12 (b) Those located within nonurban counties.

13 The department shall array the facilities in each peer group from
14 highest to lowest based on their total cost per unit of therapy for
15 each therapy type. The department shall determine the median total
16 cost per unit of therapy for each therapy type and add ten percent of
17 median total cost per unit of therapy. The cost per unit of therapy
18 for each therapy type at a nursing facility shall be the lesser of its
19 cost per unit of therapy for each therapy type or the median total cost
20 per unit plus ten percent for each therapy type for its peer group.

21 (5) The department shall calculate each nursing facility's therapy
22 care component rate allocation as follows:

23 (a) To determine the allowable total therapy cost for each therapy
24 type, the allowable cost per unit of therapy for each type of therapy
25 shall be multiplied by the total therapy units for each type of
26 therapy;

27 (b) The medicaid allowable one-on-one therapy expense shall be
28 calculated taking the allowable total therapy cost for each therapy
29 type times the medicaid percent of total therapy charges for each
30 therapy type;

31 (c) The medicaid allowable one-on-one therapy expense for each
32 therapy type shall be divided by total adjusted medicaid days to arrive
33 at the medicaid one-on-one therapy cost per patient day for each
34 therapy type;

35 (d) The medicaid one-on-one therapy cost per patient day for each
36 therapy type shall be multiplied by total adjusted patient days for all
37 residents to calculate the total allowable one-on-one therapy expense.
38 The lesser of the total allowable therapy consultant expense for the

1 therapy type or a reasonable percentage of allowable therapy consultant
2 expense for each therapy type, as established in rule by the
3 department, shall be added to the total allowable one-on-one therapy
4 expense to determine the allowable therapy cost for each therapy type;

5 (e) The allowable therapy cost for each therapy type shall be added
6 together, the sum of which shall be the total allowable therapy expense
7 for the nursing facility;

8 (f) The total allowable therapy expense will be divided by the
9 greater of adjusted total patient days from the cost report on which
10 the therapy expenses were reported, or patient days at eighty-five
11 percent occupancy of licensed beds. The outcome shall be the nursing
12 facility's therapy care component rate allocation.

13 (6) The therapy care component rate allocations calculated in
14 accordance with this section shall be adjusted to the extent necessary
15 to comply with RCW 74.46.421.

16 (7) The therapy care component rate shall be suspended for medicaid
17 residents in qualified nursing facilities designated by the department
18 who are receiving therapy paid by the department outside the facility
19 daily rate under RCW 74.46.508(2).

20 **Sec. 7.** RCW 74.46.515 and 2001 1st sp.s. c 8 s 12 are each amended
21 to read as follows:

22 (1) The support services component rate allocation corresponds to
23 the provision of food, food preparation, dietary, housekeeping, and
24 laundry services for one resident for one day.

25 (2) Beginning October 1, 1998, the department shall determine each
26 medicaid nursing facility's support services component rate allocation
27 using cost report data specified by RCW 74.46.431(6)(a).

28 (3) To determine each facility's support services component rate
29 allocation, the department shall:

30 (a) Array facilities' adjusted support services costs per adjusted
31 resident day for each facility from facilities' cost reports from the
32 applicable report year, for facilities located within urban counties,
33 and for those located within nonurban counties and determine the median
34 adjusted cost for each peer group;

35 (b) Set each facility's support services component rate at the
36 lower of the facility's per resident day adjusted support services

1 costs from the applicable cost report period or the adjusted median per
2 resident day support services cost for that facility's peer group,
3 either urban counties or nonurban counties, plus ten percent; and

4 (c) Adjust each facility's support services component rate for
5 economic trends and conditions as provided in RCW 74.46.431(6) (b) and
6 (c).

7 (4) The support services component rate allocations calculated in
8 accordance with this section shall be adjusted to the extent necessary
9 to comply with RCW 74.46.421.

10 **Sec. 8.** RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each amended
11 to read as follows:

12 (1) The operations component rate allocation corresponds to the
13 general operation of a nursing facility for one resident for one day,
14 including but not limited to management, administration, utilities,
15 office supplies, accounting and bookkeeping, minor building
16 maintenance, minor equipment repairs and replacements, and other
17 supplies and services, exclusive of direct care, therapy care, support
18 services, property, financing allowance, and variable return.

19 (2) Beginning October 1, 1998, the department shall determine each
20 medicaid nursing facility's operations component rate allocation using
21 cost report data specified by RCW 74.46.431(7)(a). Effective July 1,
22 2002, operations component rates for all facilities except essential
23 community providers shall be based upon a minimum occupancy of ninety
24 percent of licensed beds, and no operations component rate shall be
25 revised in response to beds banked on or after May 25, 2001, under
26 chapter 70.38 RCW.

27 (3) To determine each facility's operations component rate the
28 department shall:

29 (a) Array facilities' adjusted general operations costs per
30 adjusted resident day for each facility from facilities' cost reports
31 from the applicable report year, for facilities located within urban
32 counties and for those located within nonurban counties and determine
33 the median adjusted cost for each peer group;

34 (b) Set each facility's operations component rate at the lower of:

35 (i) The facility's per resident day adjusted operations costs from
36 the applicable cost report period adjusted if necessary to a minimum

1 occupancy of eighty-five percent of licensed beds before July 1, 2002,
2 and ninety percent effective July 1, 2002; or

3 (ii) The adjusted median per resident day general operations cost
4 for that facility's peer group, urban counties or nonurban counties;
5 and

6 (c) Adjust each facility's operations component rate for economic
7 trends and conditions as provided in RCW 74.46.431(7) (b) and (c).

8 (4) The operations component rate allocations calculated in
9 accordance with this section shall be adjusted to the extent necessary
10 to comply with RCW 74.46.421.

11 NEW SECTION. **Sec. 9.** It is the intent of the legislature that the
12 changes to the nursing facility payment system under this act apply
13 retroactively to January 1, 2006.

14 NEW SECTION. **Sec. 10.** This act is necessary for the immediate
15 preservation of the public peace, health, or safety, or support of the
16 state government and its existing public institutions, and takes effect
17 immediately.

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